CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT

Any provider of services must be enrolled and have a current participation agreement with the Virginia Medicaid Program prior to billing for any services provided to Medicaid recipients. A copy of the podiatry provider agreement can be found within this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment Unit; an original signature of the individual provider is required. Continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of the provider license. Failure to renew the license through the licensing authority shall result in the termination of the Medicaid Participation Agreement.

Upon receipt of the above information, a seven-digit Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

In order to become a Medicaid provider of services, the provider must request a participation agreement by writing:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Licensure by the Department of Health regulatory boards does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the

following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department.

- Assure freedom of choice to recipients in seeking medical care from any Medicaid enrolled provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.

- Assure the recipient's freedom to reject medical care and treatment or services.

- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, creed, or national origin.

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act).

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge the Department for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept as payment in full the amount established by the Department to be reasonable payment. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the Medicaid Program, providing that the recipient was Medicaid eligible at the time service was rendered. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Accept assignment of Medicaid benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document

fully and accurately the nature, scope, and details of the health care provided.

Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation for medical records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized department purposes only all medical assistance information regarding recipients. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state or federal agency. The state agency shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by licensed podiatrists.

Licensed Podiatrists

Any podiatrist licensed to practice in the Commonwealth of Virginia (or in the state in which he/she practices) may apply for participation in the Virginia Medicaid Program by signing the authorized Participation Agreement, DMAS-101 (see "Exhibits" at the end of this chapter). The agreement must be in effect at the time services are rendered in order for them to be considered for payment. Each podiatrist will be assigned a Virginia Medicaid provider identification number. Medicaid can pay only for services performed by the participating podiatrist or under his direct, personal supervision; however, a podiatrist may not bill for services provided by another podiatrist.

CERTIFICATION

The Virginia Medicaid Program is dependent upon the participation and cooperation of providers who provide or oversee **all categories** of health care. The provider is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice and economic considerations.

Providers, General

A podiatrist who admits a patient to a hospital may order tests, drugs, and treatments; and determine the length of stay. The Program calls for substantiation of certain provider decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is certification concerning the necessity of the services furnished, and, in certain instances, only if there is recertification to the continued need for the covered services.

- The provider of services is responsible for obtaining the required certification and recertification statements and for retaining them on file for verification, when needed, by DMAS.

- Use of specific procedures or specific forms is not required, so long as the approach adopted by the provider permits verification that required certification and recertification statements are entered on or included in forms, notes, or other records a practitioner normally signs in caring for a patient; a separate form may be used for this purpose. Each certification and recertification statement must be separately signed by a practitioner, except as otherwise specified in this section.

- The requirements for recertification (and for certification for inpatient hospital services furnished) set forth in this section specify certain information that must be included in the statement. This required information need not be repeated in a separate statement if, for example, it is contained in the progress notes. The statement may merely indicate that the required information is contained in the patient's medical record, if this is so.

- Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored when, for example, the patient was unaware of his eligibility for the benefits when he was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Inpatient Hospital Services

The certification and recertification statement should contain the following information:

- The reason for continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study

- The estimated period of time the patient will need to remain in the hospital

- Any plans, where appropriate, for post-hospital care

Certifications and recertifications should be signed by the provider responsible for the case, by another provider having knowledge of the care who is authorized to sign by the responsible provider, or by the hospital's medical staff.

A separate recertification statement is not necessary when the requirements for a second or subsequent recertification are satisfied through utilization review. The Utilization Review Committee records are sufficient if they show that consideration was given to the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for the post-hospital care.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with Section 504 of the Rehabilitation Act.

DOCUMENTATION OF RECORDS

The provider agreement requires that medical records fully disclose the extent of services provided to Medicaid recipients. Medical records must clearly document the medical necessity for covered services. This documentation is to be written at the time service is rendered, and be legible and clear in the description of the services rendered.

Pre-existing written protocols with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. Sufficient information must be present in the medical record to support the medical necessity for the billed service. The protocol is not acceptable as a replacement for appropriate medical record documentation. A copy of the written protocol must be present in the patient's chart to be considered in any audit.

Specific points to be recorded in the medical records to meet documentation requirements include the following:

- The present complaint.
- A history of the present complaint, past medical history applicable to the complaint, and the family history applicable to the complaint.
- The positive and negative physical examination findings pertinent to the present complaint.
- Diagnostic tests ordered, if any, and the positive and negative results.

- Diagnosis(es).

- Any systemic condition that results in severe circulatory embarrassment or areas of desensitization in the legs or feet which justifies the palliative trimming of toenails or other foot lesions. See Podiatry Manual, Ch. IV, page 10, "Covered Services and Limitations," subsection entitled "NON-COVERED SERVICES AND LIMITATIONS."

- Treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have the quantities and the dosage entered in the medical record.

- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written and signed for every office, clinic, or hospital visit billed to Medicaid.

- The record must identify the patient on each page.

- Entries must be signed and dated by the responsible licensed participating provider. The documentation for the care rendered by personnel under the direct, personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

Examples of medical record documentation:

Initial Office Visit With Follow-Up

(Please note that routine, uncomplicated post-operative care is included in the global surgical procedure and may not be billed separately.)

Jan. 20, 1989 C/O of knuckle on rt. big toe sticking out and pain on walking.
Referred by family physician.
Gradual onset over 4 months with increasing pain. Unable to wear closed shoe.
No drug allergies.
No current meds.
No illnesses.
First MTPJ (rt) pain on ROM. Can't stand on ball of foot without pain. X-rays show
rt. hallux with phalangeal deformity, displaced met. head.
Painful hallux valgus deformity rt. foot.
Patient informed of risks of surgery and alternative treatments.
Schedule for modified Austin bunionectomy rt.
Feb. 20 1989 2 wks. S/P mod. Austin bunionectomy rt.
Min. swelling around op. site. Incision clean and healing.
Pain controlled with Ibuprofen 200 mg. q4-6 hours

- All billed laboratory services must have documented results. Those laboratory

tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests must be documented as positive or negative. Those laboratory tests requiring descriptive results must be fully documented. Documentation examples are listed below:

Quantitative:
Glucose - 85 mg/dl
WBC - 7,000/mm^3

Qualitative:
Antistreptolysin screen - negative

Descriptive tests:
Urine microscopic - clear, yellow-brown, few WBC, rare renal epithelial cell
X-ray (left foot) - no abnormal findings

CLARIFICATION OF CURRENT PROCEDURAL TERMINOLOGY DEFINITIONS

Brief Level of Service - A documented abbreviated system evaluation. A brief office visit may indicate a recheck of a complaint for one system with previous treatment continued or discontinued if the problem is resolved.

Limited Level of Service - A documented limited or interval one system evaluation. Tests to support the diagnosis may be ordered with the results documented.

Intermediate Level of Service - A documented multiple systems review. One or more conditions may be new complaints or there may be one new complaint with a follow-up for a previously identified condition.

Extended Level of Service - History, diagnosis and treatment for two or more systems are documented. There may be new or existing problems. The past medical history as well as history of the present medical complaint is done.

Comprehensive Level of Service - A complete history, diagnosis and treatment plan provided are documented. A comprehensive level of service may include a family history, past medical history, a personal history and a history of the chief complaint, or a complete systems review and physical exam.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. However, written notification of voluntary termination must be made to FHS/PEU and the

Director, Department of Medical Assistance Services, thirty (30) days' prior to the effective date.

A participating provider may terminate his participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Enrollment and Certification Unit, Department of Medical Assistance Services.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 2-2-4000A et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, Section 32.1-313.1. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

☐ If you wish to be a MEDALLION PCP, check this box. The MEDALLION provider enrollment form must be attached.

☐ If you are already a MEDALLION provider, check this box.

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
INDIVIDUAL NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees**
5. **that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
6. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
7. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
8. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
9. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
12. **If qualified to be a Primary Care Provider, the applicant agrees to comply with all applicable MEDALLION state and federal laws, administrative policies and procedures of DMAS, and the requirements identified in Appendix A as from time to time amended.**
13. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*

Director, Division of Program Operations Date

For Provider of Services:

Original Signature of Provider **Date**

Provider Specialty

_____City OR _____County of _____

Board License Number **(Area Code) Telephone Number**

IRS Identification Name (Required)

mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803
1-804-270-7027

IRS Identification Number (Required) **UPIN**

Medicare Carrier and Vendor Number